DOCUMENT RESUME

ED 408 379 UD 031 731

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TITLE	The New Morbidity: Risk Factors Associated with Violence.
PUB DATE	[97]
NOTE	13p.
PUB TYPE	Reports - Research (143)
EDRS PRICE	MF01/PC01 Plus Postage.
DESCRIPTORS	*At Risk Persons; Behavior Patterns; *Black Youth; Costs; Crime; Databases; Homicide; Males; Models; *Public Health; *Risk; Socioeconomic Status; Suicide; Urban Youth; *Violence
IDENTIFIERS	African Americans; *Kentucky; *Morbidity

ABSTRACT

An increasing number of young black males are over-represented among youth who are involved in homicides, accidents, and suicides. This is being called the "new morbidity," a term coined to describe the interrelationship of self-destructive and life-threatening behaviors particularly applicable to African American males. The new morbidity refers to conditions evolving from economic, cultural, and social forces. This report describes the results of a study that uses a "public health model" to examine a set of risk factors associated with an integrated approach to the study of violence. A proposal is offered for addressing the situation from a public health perspective. The study was designed to provide a more comprehensive understanding of assault victims' risk exposure and the resources directed at those risks by using the University of Kentucky trauma program database for July 1990 through September 1996. There were 1,410 records available. The majority of victims of violence (75.8%) were male, and young people were victimized most often. Of these cases, 135 black males and 188 white males were victims. Gunshot wounds and stabbings were the most common forms of violence recorded. Data support the belief that people in central cities have higher victimization rates and more severe injuries. Many surviving victims had extremely serious injuries, a finding that suggests the importance of further research into the costs and lost quality of life due to crime victimization. Victim outcomes might be enhanced by effectively linking public health data with police crime reports. (Contains 17 references.) (SLD)

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ED 408 379

The New Morbidity: Risk Factors Associated with Violence

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An increasing number of young black males are over represented among youth who are involved in homicides, accidents and suicides. This is being called the "new morbidity," a term coined to describe the interrelationship of self-destructive and life-threatening behaviors particularly applicable to African-American males. The new morbidity refers to life-threatening diseases or disabilities which are primarily caused by social rather than biological factors. Contrasted with infectious and chronic diseases with a known organic etiology, these conditions evolve from economic, cultural and social forces (Gibbs, 1985). The results are self-destructive behaviors, high-risk activities and deviant life-styles.

This presentation will address some of the social, political and interpersonal implications for individuals and society, related to the non-fatal physical and emotional disabilities, that are impacting young black males today. Specifically, this presentation will describe the results of a study that utilizes a "public health model," which is used to examine a set of risk factors associated with an integrated approach to violence. This paper will also deal with the cost of disabilities resulting from acts of violence, for both victims and perpetrators. Some implications for society will be discussed and a proposal for addressing the situation from a public health perspective will be offered.

Violence is difficult to define clearly. Street crimes, domestic abuse, and school-related offenses are only a few of its characteristics. A central and defining feature of violence is that it produces injury or death (Koop & Lundberg, 1992). To date, no widely accepted definition of violence exists because there are different kinds of violence and each may have different causes. For example, violence can occur during the commission of a crime, an interpersonal dispute, or a confrontation between strangers. In 1992, the National Center for Injury Prevention and Control adopted an inclusive definition that violence is the threatened or actual use of physical force against oneself or an individual or group that either results, or is likely to result, in injury or death.

Violent and abusive behaviors contribute to major causes of death, injury, and stress in the United States. In 1990 , suicide and homicide resulted in over 31,000 deaths (U.S. Department of Justice, 1992). Firearms play an increasingly major role in both interpersonal and self-directed violence, especially among younger victims. Since the mid-1980's, rates of teenage violent crime reported to police departments in the nation's cities have increased significantly. Most seriously, annual murder counts among teenagers in recent years have hovered around 24,000, an unprecedented number. In addition, some 2.9 million serious nonfatal violent crimes per year are being reported to the United States Department of Justice (1992). Violent intentional injury is emerging as a central threat to the nation's health, particularly among minorities and young people (Widom, 1992).

Ingram and Feldman (1992) found that violence produces extensive physical costs and emotional consequences for immediate victims, families, and society at large. Violent injuries impose costs on victims for medical treatment, physical and psychological rehabilitation, and lost productivity. These costs, plus that of the criminal justice response, have been estimated at $60 billion annually (U.S. Department of Justice, 1996). The cost of crime has two major

dimensions-- a dollar amount calculated by adding up property loss, productivity loss, medical bills, and an amount less easily quantifiable, because it takes the forms of pain, emotional trauma, and fear of death and injury from victimization (Cohen, 1990). Victimizations generate roughly $105 billion annually in property and productivity loss and outlays for medical expenses. This amounts to an annual "crime tax" of roughly $425 per man, woman, and child in the United States. When the values of pain, long-term emotional trauma, disability, and risk of death are put in dollar terms, the costs are estimated to rise to $450 billion annually or $1,800 per person (Bureau of Justice Statistics, 1992).

Although the public fear of being victimized in a violent crime, such as rape, robbery, or street assault has increased since the mid-1980's overall crime rates have not increased substantially. However, aggregate crime statistics do indicate significant increased violent crime victimization of teenagers. African-American youths, and young adults in particular, are more affected by violent crime than other groups. Black teenage males had the highest risk of victimization (113 per 1,000), followed by black teenage females (94 per 1,000), white teenage males (90 per 1,000), young adult black males (80 per 1,000), young adult black females (57 per 1,000), white teenage females (55 per 1,000), and young adult white males (35 per 1,000) (Roth, 1994).

The consequences of violent crime pose serious health and economic problems to victims. To help understand the magnitude of victim problems, the following excerpts were derived from the U.S. Department of Justice, 1992:

- On average, 2.2 million victims are injured from violent crime each year; 1 million receive medical care; 5 million are treated in an emergency room or hospital.
- Among those victims injured in rapes, robberies, and aggravated assaults in recent years, an estimated 22,870 received gunshot wounds each year, another 76,930 received knife wounds, and 141,460 suffered broken bones or teeth knocked out.

- In 1989, the estimated cost of violent crime (excluding homicide) to victims was about $1.5 billion, which included losses from medical expenses, lost pay, property theft and damage, cash losses, and other crime-related costs.

A research study by the Bureau of Justice Statistics (1992) has shown a relationship between certain demographic characteristics and the risks of overall crime victimization. Males, younger persons, Blacks and Hispanics tend to have higher rates of victimization than persons who do not possess these characteristics. Persons under age 25 had higher violence victimization rates than older persons. In general, persons from households with low incomes experienced higher violent crime victimization rates than did persons from wealthier households. Residents of central cities had higher rates for all personal victimization crimes than did suburbanites or residents of nonmetropolitan areas (DeJong, 1994).

The "new morbidity" is a term coined to describe the interrelationships of self-destructive and life-threatening behaviors among American youth; it is particularly applicable to young black males (Gibbs, 1988). The new morbidity refers to life-threatening diseases or disabilities which are primarily caused by social rather than biological factors. In contrast to infectious and chronic diseases which have a known organic etiology, the new morbidity conditions stem from social, cultural, and economic forces that foster high-risk activities, self-destructive behaviors, and tragic outcomes.

Some of the most significant factors contributing to the new morbidity for black youth have been found to be poverty, discrimination, family breakdown, unemployment, and community disorganization (Wilson, 1987). Those factors are important, but the high levels of interpersonal violence and self-destructive behaviors among black youth cannot be adequately explained simply by a sociological analysis alone (Anderson, 1994). The influence of societal and subcultural attitudes toward violence, the impact of the mass media's glamorization of violence and drugs, the easy availability of handguns, and the black community's attitudes

toward the police have been found to be key contributing factors (Prothrow-Stith, 1991).

The public health approach has traditionally depended on the cooperation of many disciplines and bureaucracies. Multi-tiered strategies are employed that address different segments of the population and are used routinely. For example, these public health interventions, known as primary, secondary, and tertiary prevention strategies may also speak to the needs of violence-prone youth (Prothrow-Stith, 1991). Using the public health model to prevent violence or lessen its impact calls for identifying the major factors that put young people at risk for violence, in order to reduce or eliminate these factors and strengthen the protective factors that buffer the effects of exposure to risk. The following are some of those factors:

- Community and Social Environment : Risk factors arising from the community and environment are known to increase the probability that a young person will engage in violence.
- Families: The home environment, family dynamics, and parental stability are risk factors that play a major role in shaping behavior associated with violence.

  Individual and Peer Groups: Individuals with psychosocial problems who associate with peers engaged in problem behaviors (for example, drug abuse, delinquency, violence, sexual activity) are at risk of violence.
- Biological: A wide range of biological risk factors have been determined to be indirectly associated with violent behavior.

A variety of protective factors may buffer exposure to risk. Protective factors are conditions that are found to help buffer young people from the negative consequences of exposure to risk, by either reducing the impact of the risk or changing the way a person responds to the risk (Howell, 1995). The following factors have been found to buffer exposure to risk:

- Individual characteristics: Exhibit a resilient temperament, positive social orientation, gender and intelligence.

- Bonding: Establish positive relationships with family members, teachers, or other adults. Providing opportunities for active involvement with youth; consistent positive reinforcement; ing access to necessar havy skills.
- Healthy beliefs and clear standards: Create a bond to those who did believe in young people's competence to succeed in school and avoid drugs and crime coupled with establishing clear expectations and rules governing their behavior.
- Community Policing: Help play an active role helping in community-guided violent behavior problem solving, cooperation and mutual trust.
- Preventive Programs and Rehabilitation: Can be utilized multi disciplinary interventions focused on high risk youth, victim rehabilitation, and prevention programs.

Where preventive approaches seek to minimize factors associated with youth gun violence, tertiary interventions are designed for young people already engaged in and/or affected by high-risk activities. Tertiary intervention programs, after patterns of delinquency and violence are established, more actively engage law enforcement and health providing agencies.

The intangible costs, such as the lost quality of life, are estimated as being the largest cost component for victims of violent crimes. Lost quality of life is also subject to the most uncertainty. A 1992 study by Bastian found that the cost of intangible pain, suffering, and lost quality of life generally exceeds all other tangible categories combined. Prothrow-Stith (1991) found that the data in record keeping systems of most medical care facilities and law enforcement agencies do not adequately monitor or utilize non-fatal violent injury data. Most hospital admission databases do not include follow-up information on individuals who are treated and released. Law enforcement databases, which are usually indexed by offense, rarely track victims or perpetrators unless they remain within the criminal justice system (MaCaig, 1994). An exception is Emory University which in conjunction with the Georgia Bureau of

Investigation recognized the problem and recently initiated an effort to link police and public health records in several cities in an effort to discern "hot spots," patterns and trends related to victims and perpetrators of non-fatal, violence-related injuries.

The purpose of this study was to help design a more comprehensive understanding of assault victim's risk exposure and the resources directed at those risks using the University of Kentucky trauma program data base from July 1990 to September 1996.

Method

The study data included two sets of trauma records , 411 from Lexington, Kentucky and 999 patients state wide who were injured in various types of assault from a five-year database 1990-1996, conducted by the Department of Surgery Trauma Center at the University of Kentucky Hospital. This study data represent patients in Fayette County, Kentucky.

The trauma surgery unit at the University of Kentucky Hospital is one of five admitting services and represents 37% of the total hospital patients. The department had an average of 2500 total patients admitted each year between 1990-1996. The patients represented in this study were identified as being injured in several categories of assault.

Results

The data base was analyzed regarding patient demographic characteristics and discharge outcomes. These data revealed that the victims of assault ages 14-25, numbered 138 and represented 33.7% of the total. Those between the ages of 25-35, represented 124 victims and 30% of the group. The cause of injury for all Lexington victims N = (411), was 151(36.7%) gunshot wounds; 146 (35.5%) stab wound and 81 (19.7%) homicide victims.

Data for the Lexington area showed that 24.2% were females and the vast majority (75.8) male. There were gunshot wounds (16.4%) female 127 (84.6%) male. There were 29 (19.9%) females with stab wounds and 117 (80.1%) stabbed males. There were 13 (16.3%) homicide females, and 67 (83.8%) males.

The discharge destination findings for Lexington revealed that 321 (79.1%) went home, 5 (1.2%) went to other hospitals and long term care facilities, 12 (3%) went to rehabilitation facilities, 32 victims (7.9%) went to jail, foster care etc., and 36 (8.9%) went to the morgue.

The locations of where the injuries occurred victims in Lexington were 76 (18.5%) in public buildings, 1 (.2%) during recreation, 5 (1.2%) in a residential facility, 63 (15.3%) were unknown, 153 (37.2%) occurred at home, 8 (1.9%) jail, foster care etc., 9 (2.2%) on the job, and 96 (23.4%) dropped on the street. Statewide data revealed that 148 or (14.8%) occurred in public buildings, 189 or (18.9%) were unknown, 460 or (46.1%) at home, and 145 or (14.5%) occurred on the street.

The sex and race of the victims indicated that there were 0 Asian females and 1 Asian male, 39 Black females and 135 Black males, 0 Oriental females and 2 Oriental males, 0 Hispanic females and 11 Hispanic males, and 35 White females and 188 White males.

The type of trauma for victims described as blunt or penetrating was 144 (27.7%) incidents being blunt and 297 (72.3%) were penetrating for the total 411 victims. Gunshot wounds caused the greatest amount of damage to victims who were discharged to rehabilitation facilities.

Discussion

The overall effects of assaults that injure but do not kill were found to be extremely devastating to victims in this study. As it was anticipated it was especially true in the case of gunshot wounds. Demographic characteristics and risk factors revealed that there was minimal variation in the age distribution of victims admitted in the University of Kentucky Trauma Program. Younger people were victimized most often.

The data in this study supported the beliefs that people in central cities have higher victimization rates and the types of injuries were more severe than those that occurred statewide. The types of weapons most often determined the severity of the injuries. The blunt as opposed

to penetrating injuries was considerably high in the Lexington area. The degree which victims utilize rehabilitation service was minimal. The study clearly supports the need to develop the Public Health Model to establish linkages and preventive services to victims of assault.

Many of the 375 surviving victims had extremely serious injuries. The gunshot wound victims with penetrating injuries usually sustained paraplegia and quadriplegia, with severe artery, muscle and bone damage. Assault victims with blunt trauma sustained severe facial and head injuries, with numerous fractured bones and severe organ damage. Stab wounds caused serious injuries to internal organs and tissue. The follow-up discharge outcomes for the majority of these victims were unknown to the University of Kentucky staff in the hospital trauma and surgery units.

Based on the size and uncertainty of previous estimates, further research on the cost and lost quality of life due to crime victimization appears to be warranted. In a rapidly growing number of states, cause-coded hospital discharge data represent a potentially rich source for data on the most serious injuries resulting from crime. In this study, data were analyzed within the Lexington, Kentucky health care system to capture data on victimizations, but these data lack sufficient details about the related systems. Victim outcomes might also be enhanced by effectively linking public health data with police crime reports. Further research beyond this paper is needed to assess the value of linked data and the difficulty and cost of developing this linkage.

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